

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1.
  - a. Whether there should be additional reimbursement for dates of service 12/06/01?
  - b. The request was received on 03/19/02.

### **II. EXHIBITS**

1. Requestor, Exhibit 1:
  - a. TWCC-60
  - b. HCFA-1500s
  - c. EOBs
  - d. Reimbursement data
  - e. Medical Records
  - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
  - a. TWCC-60 and Response to a Request for Dispute Resolution dated 05/20/02
  - b. Audit summaries/EOB
  - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 05/03/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 05/06/02. The only response from the insurance carrier is the 3-day, which was received on 03/01/02. The carrier did not submit a 14-day response.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: no position statement submitted
2. Respondent: letter dated 05/20/02  
"Charges submitted by (Provider) for services of 12/6/01 included items billed with codes 99070-AS and 99070-ST for anesthesia supplies and a sterile tray. Payment was issued on 1/18/02 at a fair and reasonable rate of \$100.00 for 99070 ST and \$100.00 for code 99070 AS. Additional reduction is according to the provider's contract..."

**IV. FINDINGS**

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service eligible for review is 12/06/01.
2. The carrier's EOBs have the denial, "F – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUE AS ESTABLISHED BY INGENIX."
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
12/06/01	99070-ST	\$417.40	\$85.00 (\$100.00 less 15%)	F	DOP	MFG; SGR (V)(B)(1-2), General Instructions (GI) (III)(A); Texas Workers' Compensation Act & Rules, Sec. 413.011 (d)	The issue is what is "fair and reasonable" reimbursement for the service rendered. The referenced GI states, "... (DOP) in the ... (MAR) column indicates that the value of this service shall be determined by written documentation..." The burden is on the Requestor to show that the amount of reimbursement requested is "fair and reasonable." The provider has only submitted an itemized list of charges that make up the total billed amount. The provider has not submitted documentation that demonstrates that the amount of reimbursement requested is "fair and reasonable" or that meets the criteria of Sec. 413.011 (d) of the Texas Labor Code. Therefore, no additional reimbursement is recommended.
12/06/01	99070-AS	\$661.30	\$85.00 (\$100.00 less 15%)	F	DOP		
<b>Totals</b>		\$1,078.70	\$170.00				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 19<sup>th</sup> day of June, 2002.

Larry Beckham  
Medical Dispute Resolution Officer  
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.